NLC NATIONAL LEAGUE OF CITIES

A CENTURY OF STRENGTHENING CITIES

Making Impact Visible: Using Data & Narrative to Drive Alignment

June 11, 2026

OUR MISSION

To relentlessly advocate for, and protect the interests of, cities, towns, and villages by influencing federal policy, strengthening local leadership, and driving innovative solutions.

Agenda

NLC NATIONAL LEAGUE OF CITIES
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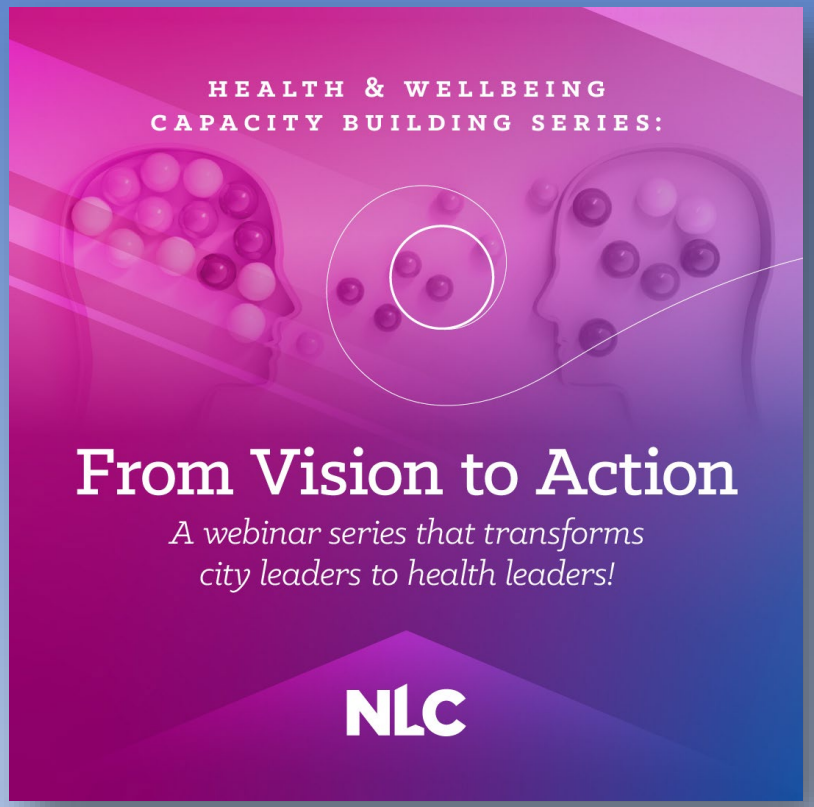
1. Introduction
2. Data for Wellbeing: Best Practices in Measuring Interconnected Systems, Impact and Outcomes
3. Creating Data Stories for Humans
4. Using Data to Make Decisions
5. Q&A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Creative Processes:
Expanding Impact
Through Arts & Culture
JULY 9
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Learning Objectives

Today, you will learn how to connect data to meaningful narratives, translate quantitative and qualitative data into compelling, human-oriented stories!

Apply ethical, accessible data practices that are transparent, inclusive, and easy to understand

Explore how storytelling can be used to build trust and alignment

Elevate community voice alongside data to ensure communications reflect community realities and priorities

Demonstrate impact to inform decision making

Learn from real world examples

Who We Are

Julie Steenson and Kate Bender

Co-Founders, PorchLight Insights

- **Background**: Former co-leads of Kansas City, Missouri's DataKC office
- **Mission**: We strengthen the public sector from within, championing data-informed, people-centered cultures that work well for everyone.

Data for Wellbeing:

Best Practices in Measuring Interconnected Systems, Impact and Outcomes

Evolving State of Data for Well-Being

Community narratives on health equity and collective well-being are still developing.

Although some communities recognize that health inequity and structural racism exist, they struggle to **turn awareness into sustained action** that can address these issues.

Additionally, discussions about individual well-being are emerging, but there is **limited attention paid to collective well-being,** a concept that recognizes intersections between people and place in the context of well-being.

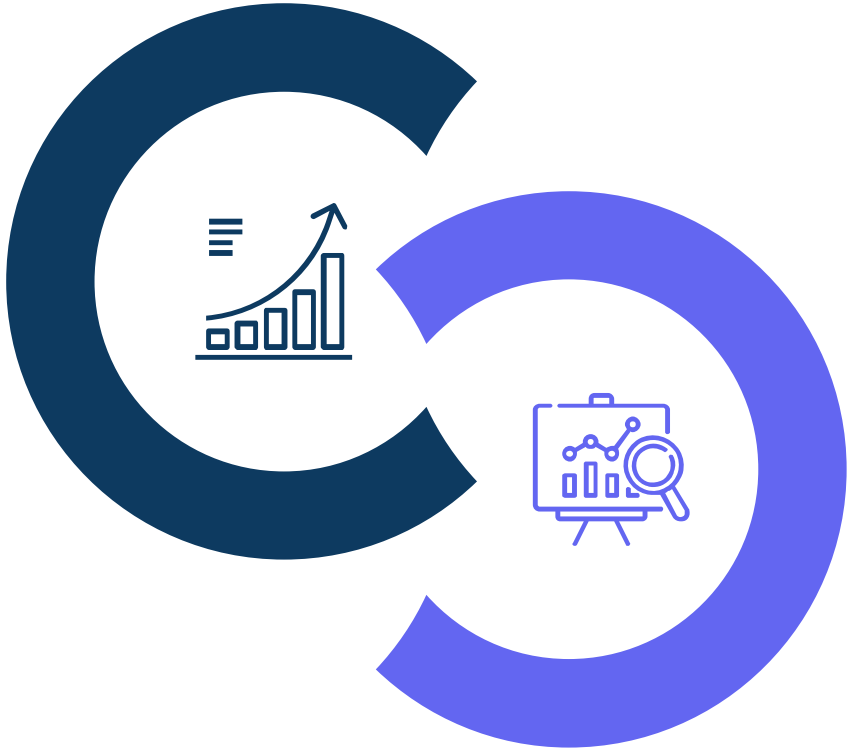
Communities also find it challenging to **tie health equity to other priorities**, such as economic development.

- Rand Align for Health and Well-Being Toolkit

Two Interlocking Ways to Think About Data

Performance Measures

Static, top-level aggregate numbers that are tracked at intervals.



Data

The raw or disaggregated information that can be analyzed

Many orgs stop at measuring, but data is where the deeper insights live.

What we're used to measuring vs. what we need to measure

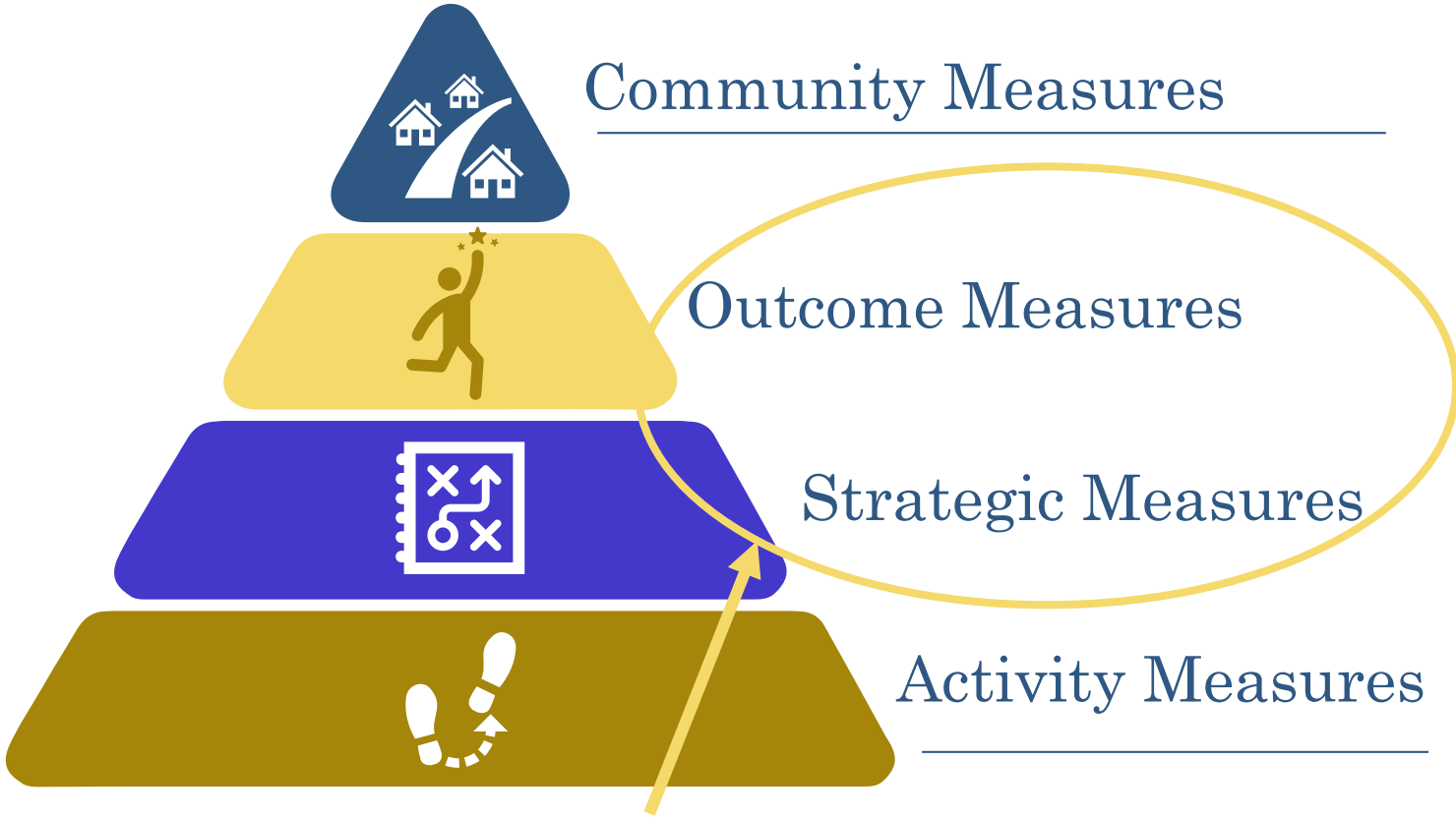
Clinical health stats	How basic clinical stats impact quality of life; not only physical health but also mental and behavioral health
Access to medical care	Quality of care; effort involved in obtaining care (how far do you have to drive to receive care)
Service interactions	Did your service make a difference?
Jobs created; $ invested	Job satisfaction and employee engagement

Levels of Measurement

All levels provide value and insight to your efforts.

It is important to be able to link measures at all levels using your Theory of Change.

I.e.: If we complete this activity, it will contribute to the strategy. The strategy has been designed to impact the outcome. The outcome has an impact on the community.



The connection here is often biggest challenge

Community & Outcome Measures

Community measures are high-level indicators for your population that describe the conditions in your community

Outcome measures are tied to a strategic goal and represent something you are actively trying to impact

Demographics and population

Who lives in your community and what differences exist between groups who live in your community?

Example: Life expectancy

Environmental

What environmental factors impact your community's wellbeing?

Example: Excessive heat days

Economic

How are people doing financially and in their employment?

Example: Self ratings of economic stability

Clinical Outcomes & Impact

What happens to your community members when they get sick?

Example: Cardiac deaths

Community connectedness

How much does your community feel that they can depend on each other, or have support?

Example: Resident ratings of connection

Survey Best Practices

Be thoughtful about audience

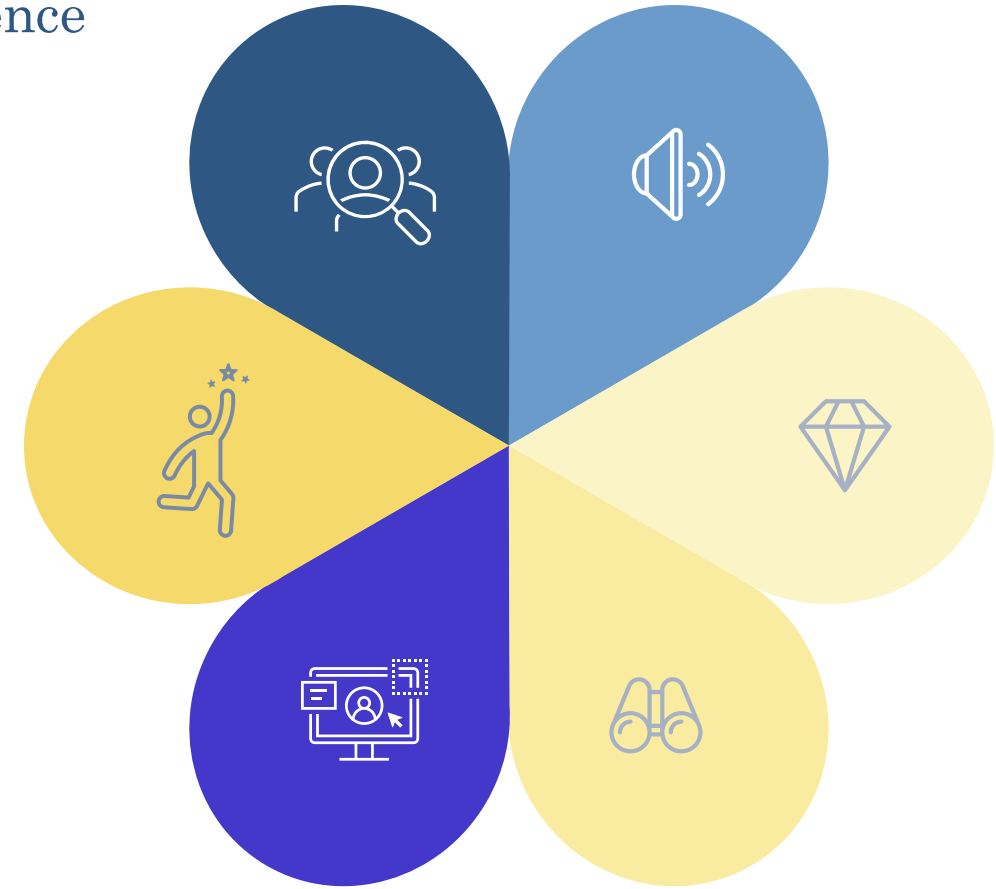
Random sample, population-wide, and specific audience focus can all be the right call

Align questions with goals

Figure out what you NEED to know and ask that. Every question should be meaningful!

Make it user-friendly

Readable at a middle school level and not too long or complicated



Go to where your audience is

Don't try to reinvent the wheel with administration; rely on existing communications channels

Establish trust

Assure participants of anonymity and handle data appropriately to protect PII

Dig in to find key insights

Use demographic questions to gather info for key crosstabs

Survey Best Practice Examples

	City of Rancho Cucamonga, California	Henry County/Martinsville, VA Health Department
Goal	To gather data to support their HealthyRC initiative	To understand the needs of marginalized residents for their CHA
Innovations	• Questions across spectrum of wellness – chronic health, healthy eating, mental health, connectedness, economic wellbeing • Self administration through program communications	• Simplified survey to 5 questions at 6th grade reading level • Used community health worker to gather data door-to-door • Defined target census tracts for outreach based on target audiences
Outcomes	Opportunity to examine perspectives across subject areas	New barriers identified and used to create workgroups to improve health equity

Strategic & Activity Measures

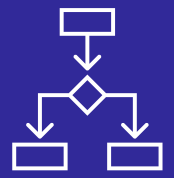
Usually easy to measure and provides steady information on progress of strategic actions being taken in your community.

Not fully measuring ultimate goals, but good for assessing the progress on programs and activities that contribute to outcomes in your theory of change.

Program Use and Demand

How many people used this program? Was there a waitlist?

Example: Number of participants



Program Outcomes & Impacts

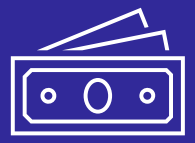
Did your program change behaviors or provide medium- to long-term change?

Example: Participants stably housed

Customer Satisfaction

How did people feel about your service or program?

Example: Customer ratings of program



Resources Used

How much in money, time and effort went into delivering your program or service?

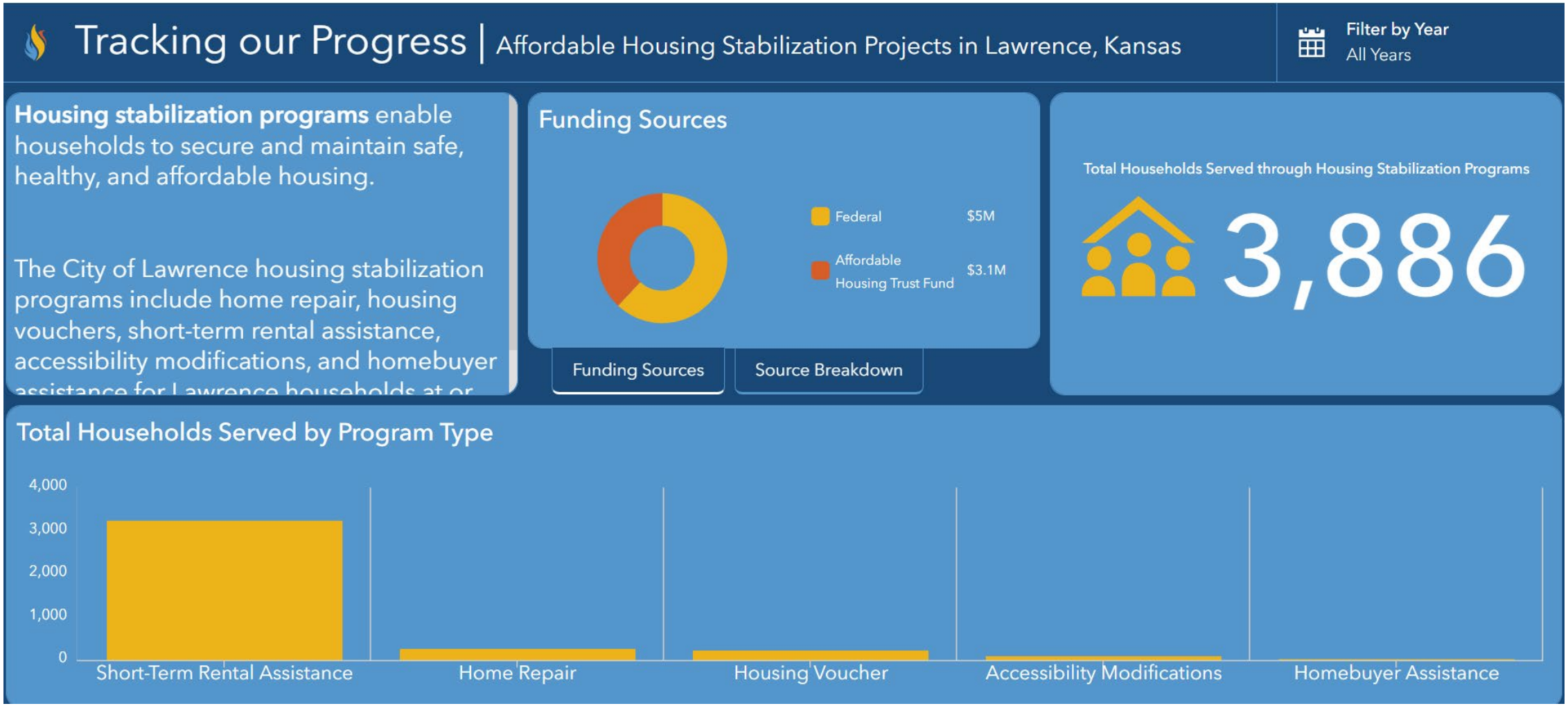
Example: Case worker hours

Program Timeliness

How long did it take for your to deliver program elements?

Example: Application processing time

Example from Douglas County, KS: A Place for Everyone



Source: https://www.dgcoks.gov/news/2025/05/06/new-dashboard-provides-real-time-data-homelessness

What shared outcome is hardest to measure in your community?

Big Lessons in Collecting and Using Good Data

Data Quality

How you get your data matters!

- Systematically check for errors in data entry and completeness
- Ensure fields are used properly and are standardized where possible
- Consider who your data represents in your community and who may be left out

Data Availability

Where you get your data matters!

- Consider how difficult the data is to get and weigh the costs
- Use trusted sources or data already validated by others
- If the data you want does not exist, create it or find proxy data!

Creating Data Stories for Humans

Three steps to effective data storytelling

Understanding audiences

Audience questions and impacts

1. How much do they know? → **context**
2. What is the "hook" for them? → **data story**
3. What do you want them to do? → **call to action**

Mayor

1. General knowledge
2. Insights relating to priorities
3. Elevate, convene, allocate

Program Manager

1. Everything
2. Operational insights
3. Brainstorm, collaborate, address

Public

1. Nothing
2. Information pertinent to their lives
3. Advocate, vote, make a choice

Tip: Never make an audience feel "dumb" about data!

Example from Carver County CHA

This example is from their CHA, which is in an ArcGIS public-facing website.

This data on preventative health care also includes frequency – **an embedded call to action.**

Frequency of Preventive Health Care

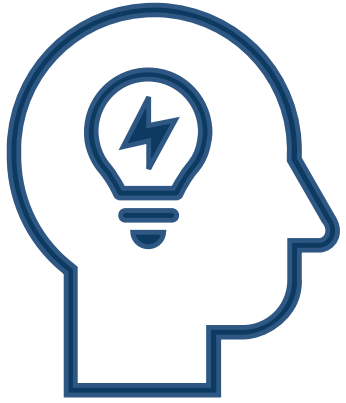
The expense of health care also shows up when people delay or avoid getting preventive care because they cannot afford the cost or cannot find a provider. The 2023 Carver County Community Health Survey asked people when they got preventive care. Responses show that many people have not gotten the preventive healthcare that they should have. For example, 40% of people are not current on flu shots, and 35% have not had their blood sugar tested in the past year. [3]

Survey results showing percentage of respondents by when they last received preventive care services and the recommended frequency for each service

Preventive Care (5)	Within past year	Past 2 to 5 years	5 plus years or Never	Recommended frequency
Colonoscopy	20.2%	23.6%	56.3%	Every ten years starting at age 45
Prostate Exam	24.1%	22.8%	53.1%	Every 3-5 years starting at age 45
Mammogram	45.6%	17.3%	37.0%	Every 2 years starting at age 50
Flu Shot	60.7%	19.2%	20.1%	Every year
Pap Test	32.8%	49.6%	17.5%	Every 3 years starting at age 21
Blood Sugar Check	64.7%	19.7%	15.7%	Annually

Understanding the story you're sharing

Another way to say this is: "What is the point of this chart?"



You should **know the insight that you want someone to derive from a visual** to select and create the most impactful visual.

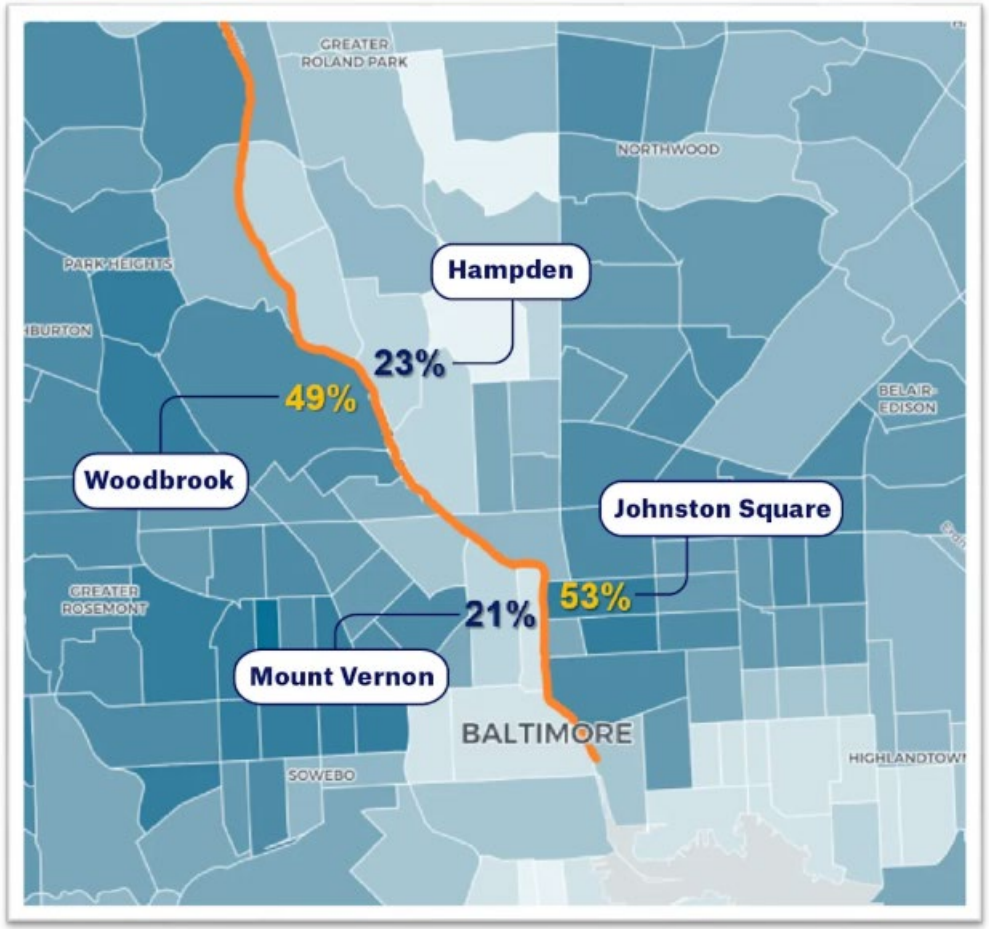
Example from City Health Dashboard

A highway runs through it

Digging deeper, we can look at a map of high blood pressure (HBP, aka hypertension) in Baltimore with the Expressway highlighted (in orange in the map below). High blood pressure is an important risk factor for heart disease and stroke, two of the leading causes of death in the United States. A clear pattern emerges in the map, even just at first glance. Digging into four neighborhoods, we can see that residents living on either side of I-83 but just across the street from each other experience hypertension very differently. In Woodbrook and Johnston Square, 49% and 53% of residents, respectively, have high blood pressure, while in Hampden and Mount Vernon, just 23% and 21% of residents, respectively, have high blood pressure. That is less than half of the rate of HPB in neighborhoods separated only by a highway.

Mar. 9, 2023

Shoshanna Levine & Jacqueline Betro



This is an example from an article about historical barriers to neighborhood health equity. It uses:

- A catchy headline to stick with you
- Underlining to pull a fact out
- Annotation, labeling, and color to point out the key data

Example from Carver County, MN CHA

State of Carver County's Social Determinants of Health

What health concerns stand out most in Carver County?

Residents report overall health is declining, with mental health and affordability leading the concerns.

- Cost of healthcare and insurance ranked as the biggest concerns.
- Housing, food, and transportation costs also ranked very high.
- Depression, anxiety, and stress were among the top ten concerns for adults.

How does income affect health?

Income strongly predicts health outcomes. Lower incomes are linked to higher risks for disease and premature death.

- Median household income in 2021: $102,694, yet 20% earned less than $50,000.
- About 5% of residents lived below the poverty line.
- 27% worried about paying rent or mortgage at some point in the past year.

Is housing affordable in Carver County?

What barriers exist to medical care?

How connected do residents feel to their community?

Is transportation a barrier for residents?

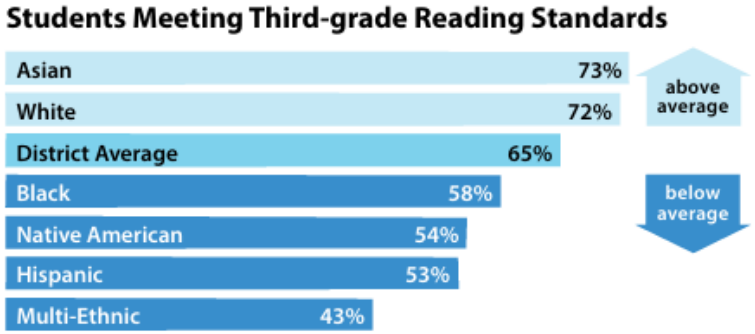
This example is from their CHA, which is in an ArcGIS public-facing website.

It has a lot of data and visuals, but also this very direct Q&A style information.

Example from Tacoma 2025 Strategic Plan

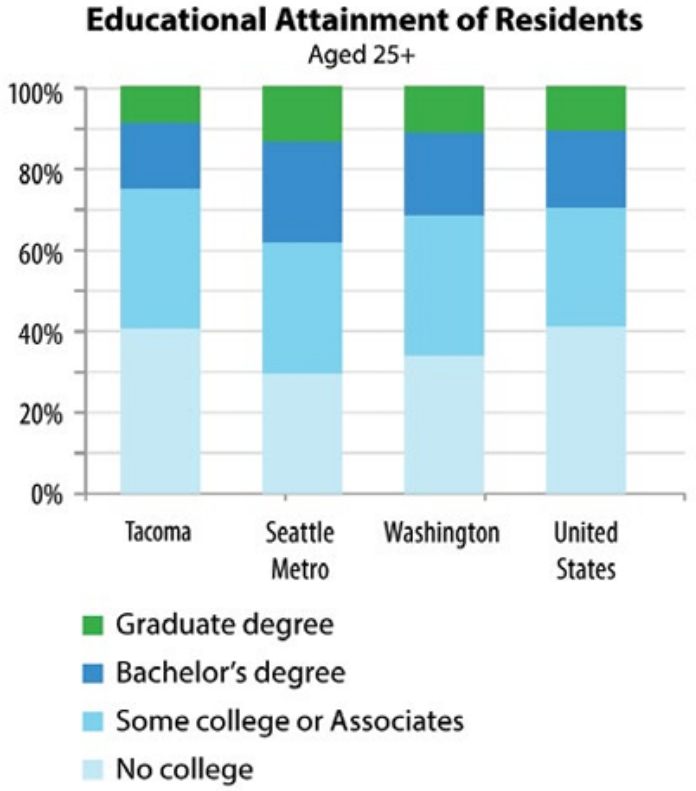
This example is from their strategic plan 2025 PDF docuement

These charts are easy to read and interpret, but ALSO the point of the chart is called out below.



Source: Washington Office of Superintendent of Public Instruction

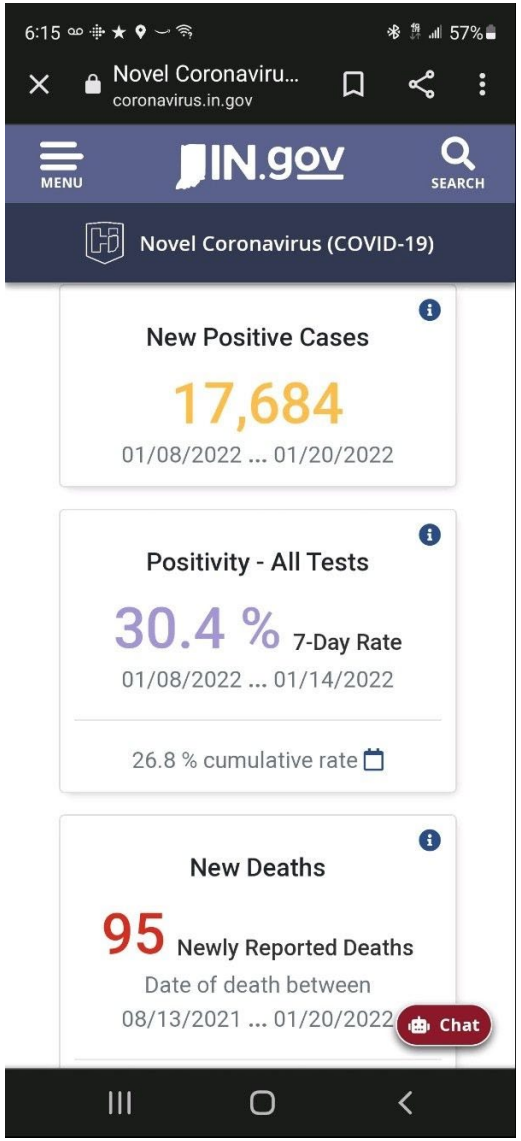
Two-thirds of Tacoma third graders meet state reading standards. Performance is lower among some racial and ethnic minorities.



Source: US Census Bureau, American Community Survey, 2010 - 2013

Tacoma's workforce is less educated than the regional workforce. This isn't the only sign of workforce preparedness, but it is important.

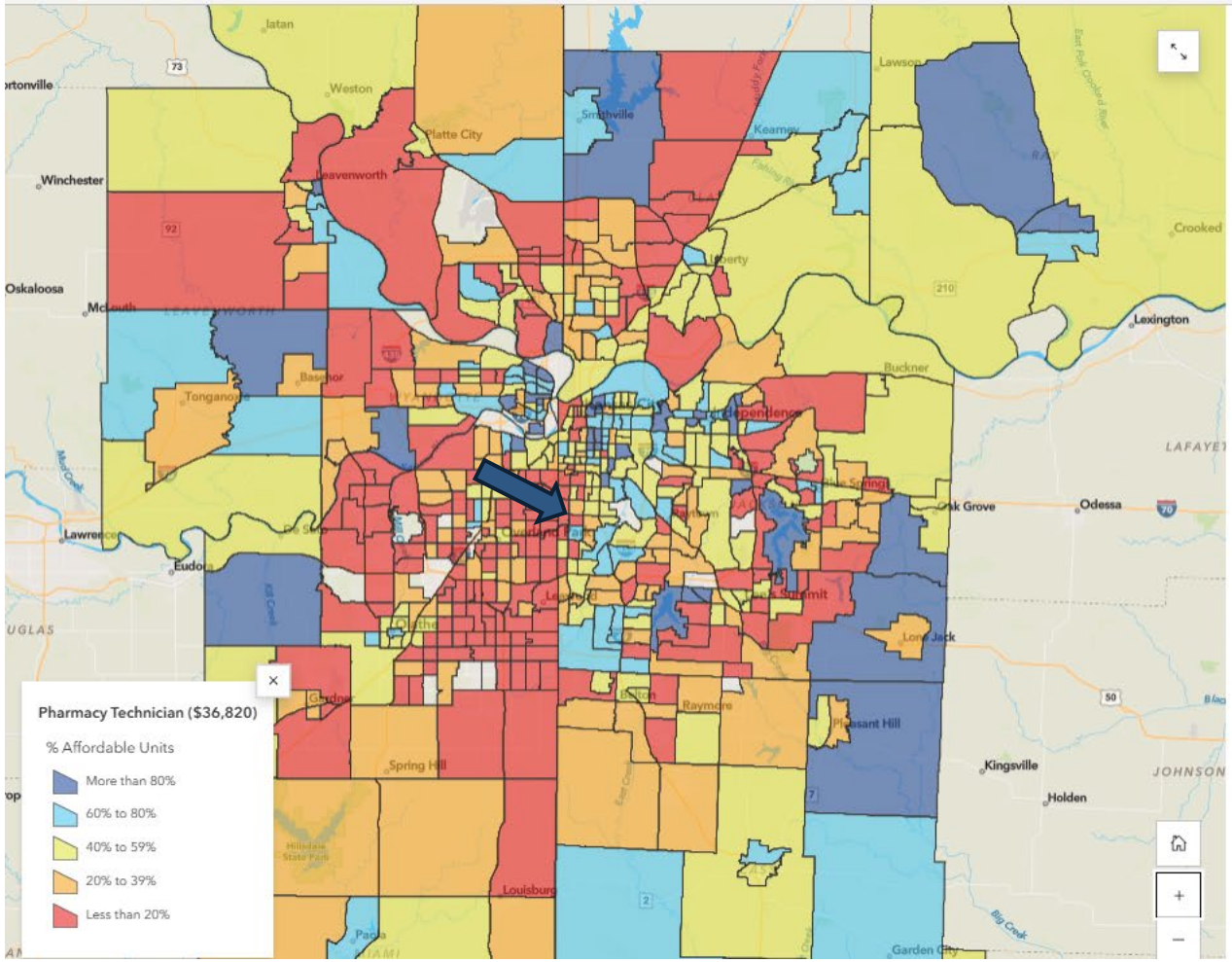
Creating data stories that resonate with humans



- Behind every data point is a story about a real person
- We get enamored with the aggregate story and forget the human underneath
- Each story is unique, but patterns emerge that deserve attention Data stories must be told with care

Creating data stories that resonate with humans

Neighborhood Essentials | Food Service | Pharmacy Technician | Delivery Truck Drivers | Teachers | Registered Nurses | Regional (Un)affordability | Background & Methodology



Pharmacy Technician

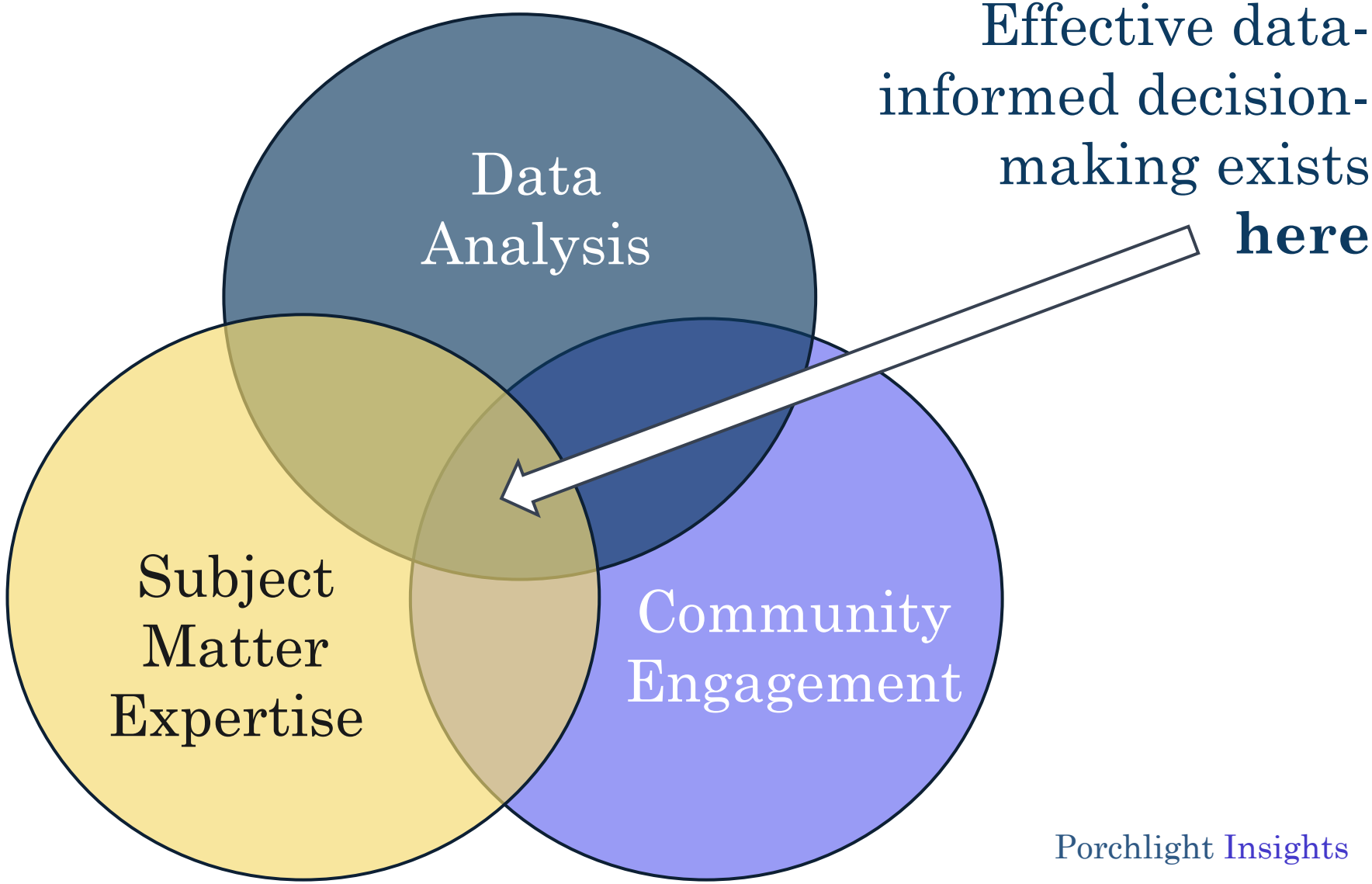
Widely trusted by the public and easily accessible in the community, pharmacy technicians are an essential part of our nation's health care infrastructure.[4] These workers help pharmacists dispense prescription medication to customers and health professionals, and routinely play an important role in providing customer service, interacting with patients while processing transactions and assisting them with insurance forms. During the pandemic, pharmacy technicians administered COVID-19 tests and vaccines while continuing to provide other live-saving medications in their communities.

Source: https://storymaps.arcgis.com/stories/04e195ab0c734c38b0f7665d8f876ce0


Think of a data story that impacted you!

Using Data to Make Decisions

What Produces Data-Informed Decision Making

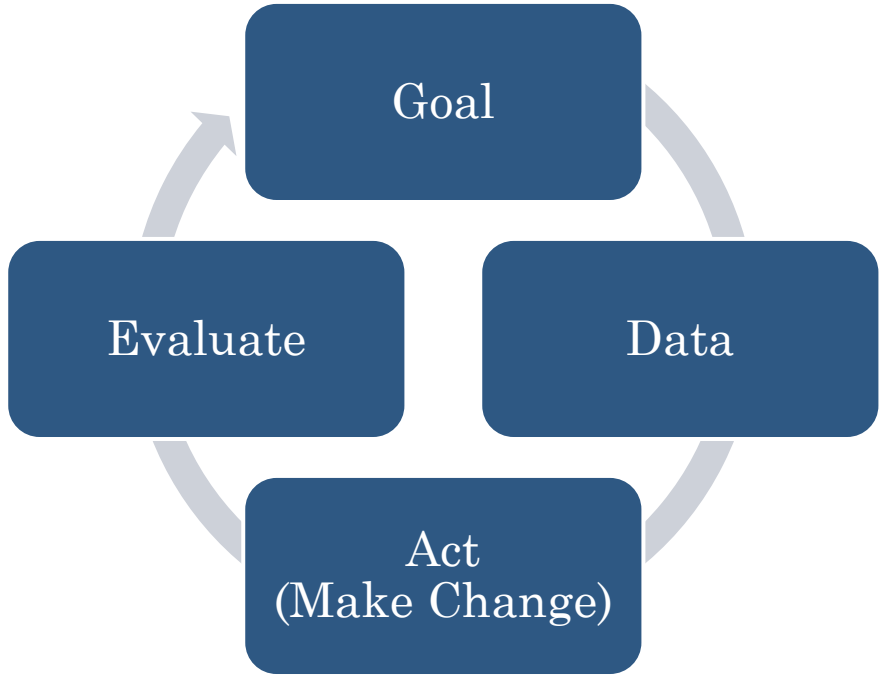


Decision-Makers

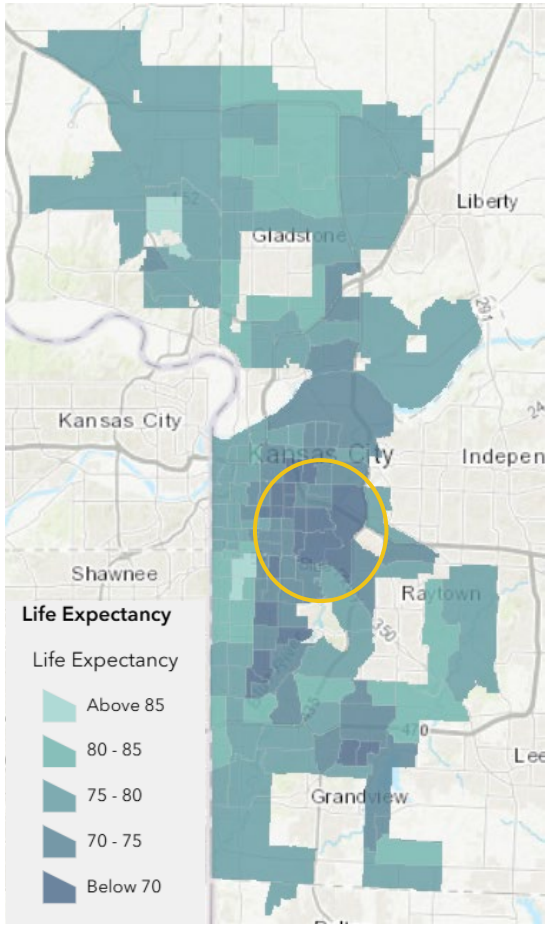
Openness to change is crucial

- Data collection, analysis and reporting only thrive in **an environment where change is possible**

- Continuous improvement is dependent on **leadership's willingness to use new information to make data-informed changes**, evaluate those changes and update their goals



Example from Kansas City, Missouri LifeX Initiative



PARK DISTRICT
QLID

https://experience.arcgis.com/experience/15137b6c1e394c33bc072387cc746652
https://healthequityguide.org/case-studies/kansas-city-organizes-lifex-summit/

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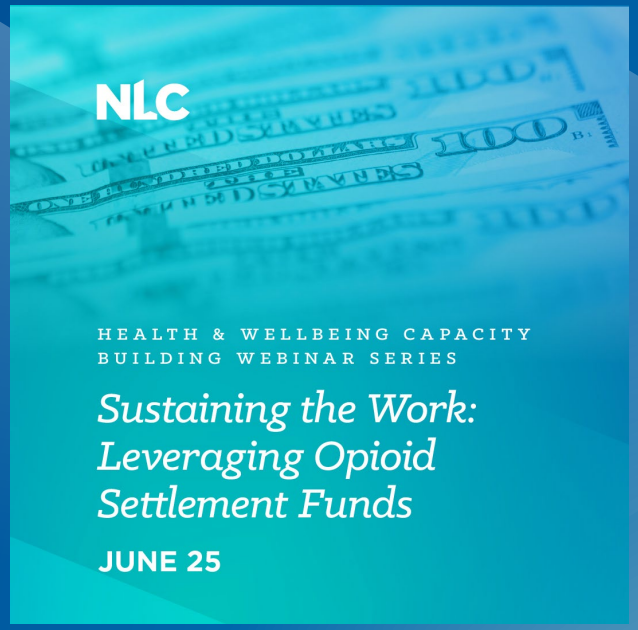

June 25th

July 9th